

State of Arizona  
House of Representatives  
Forty-eighth Legislature  
Second Regular Session  
2008

# HOUSE BILL 2658

AN ACT

AMENDING SECTIONS 20-1380, 20-2301, 20-2304 AND 20-2309, ARIZONA REVISED  
STATUTES; RELATING TO INSURANCE CONTRACTS.

(TEXT OF BILL BEGINS ON NEXT PAGE)



1 Be it enacted by the Legislature of the State of Arizona:

2 Section 1. Section 20-1380, Arizona Revised Statutes, is amended to  
3 read:

4 20-1380. Guaranteed renewability of individual health coverage

5 A. Except as provided in this section, on request of the insured  
6 individual, a health care insurer that provides individual health coverage to  
7 the individual shall renew or continue that coverage.

8 B. A health care insurer may nonrenew or discontinue the health  
9 insurance coverage of an individual in the individual market only for one or  
10 more of the following reasons:

11 1. The individual has failed to pay premiums or contributions pursuant  
12 to the terms of the health insurance coverage or the health care insurer has  
13 not received premium payments in a timely manner.

14 2. The individual has performed an act or practice that constitutes  
15 fraud or has made an intentional misrepresentation of material fact under the  
16 terms of the coverage.

17 3. The health care insurer has ceased to offer NEW coverage AND HAS  
18 DISCONTINUED ALL IN-FORCE COVERAGE in the individual market pursuant to  
19 subsection ~~C~~ D of this section.

20 4. If the health care insurer offers health care coverage through a  
21 network plan in this state, the individual no longer resides, lives or works  
22 in the service area or in an area served by the network plan for which the  
23 health care insurer is authorized to do business but only if the coverage is  
24 terminated uniformly without regard to any health status-related factor of  
25 any covered individual.

26 5. If the health care insurer offers health coverage in the individual  
27 market only through one or more bona fide associations, the membership of an  
28 individual in the association has ceased but only if that coverage is  
29 terminated uniformly without regard to any health status-related factor of  
30 any covered individual.

31 C. If a health care insurer decides to discontinue offering a  
32 particular policy form offered in the individual market, the health care  
33 insurer may discontinue that policy form only if:

34 1. The health care insurer provides notice to the director at least  
35 five business days before the health care insurer gives notice to each  
36 individual covered under that policy form of the intention to discontinue  
37 offering that policy form in this state.

38 2. The health care insurer provides notice to each individual who is  
39 covered by that policy form in the individual market at least ninety days  
40 before the date of the discontinuation of that policy form.

41 3. The health care insurer offers to each individual in the individual  
42 market whose coverage is discontinued pursuant to this subsection the option  
43 to purchase all other individual health insurance coverage currently offered  
44 by the health care insurer for individuals in that market.



1           4. In exercising the option to discontinue that type of coverage and  
2 in offering the option of coverage prescribed in paragraph 3 of this  
3 subsection, the health care insurer acts uniformly without regard to any  
4 health status-related factor of enrolled individuals or individuals who may  
5 become eligible for that coverage.

6           D. If a health care insurer elects to discontinue offering all health  
7 insurance coverage in the individual market in this state, the health care  
8 insurer may discontinue that coverage only if all of the following occur:

9           1. The health care insurer gives notice to the director at least five  
10 business days before the health care insurer gives notice to each individual  
11 of the intention to discontinue offering health insurance coverage in the  
12 individual market in this state.

13           2. The health care insurer provides notice to each individual of that  
14 discontinuation at least one hundred eighty days before the date of the  
15 expiration of that coverage.

16           3. The health care insurer discontinues all individual insurance or  
17 coverage that was issued or delivered for issuance in this state and does not  
18 renew any coverage that was offered or sold in this state.

19           E. If the health care insurer discontinues offering health insurance  
20 coverage pursuant to subsection D of this section, the health care insurer  
21 shall not issue any health insurance coverage in this state in the individual  
22 market for five years after the date that the last individual health  
23 insurance coverage was not renewed.

24           F. Subsection C of this section does not apply if the health care  
25 insurer modifies the health coverage at the time of renewal and that  
26 modification is otherwise consistent with this title and effective on a  
27 uniform basis among all individuals covered by that policy form.

28           G. A health care insurer shall provide the certification described in  
29 section 20-2310, subsection G if the individual:

30           1. Ceases to be covered under a policy offered by a health care  
31 insurer or otherwise becomes covered under a COBRA continuation provision.

32           2. Who was covered under a COBRA continuation provision ceases to be  
33 covered under the COBRA continuation provision.

34           3. Requests certification from the health care insurer within  
35 twenty-four months after the coverage under a policy offered by a health care  
36 insurer ceases.

37           H. The director may use independent contractor examiners pursuant to  
38 sections 20-148 and 20-159 to review the higher level of coverage and lower  
39 level of coverage policy forms offered by a health care insurer in compliance  
40 with this section and section 20-1379. All examination and examination  
41 related expenses shall be borne by the insurer and shall be paid by the  
42 insurance examiners' revolving fund pursuant to section 20-159.



1           Sec. 2. Section 20-2301, Arizona Revised Statutes, is amended to read:

2           20-2301. Definitions: late enrollee coverage

3           A. In this chapter, unless the context otherwise requires:

4           1. "Accountable health plan" means an entity that offers, issues or  
5 otherwise provides a health benefits plan and is approved by the director as  
6 an accountable health plan pursuant to section 20-2303.

7           2. "Affiliation period" means a period of two months, or three months  
8 for late enrollees, that under the terms of the health benefits plan offered  
9 by a health care services organization must expire before the health benefits  
10 plan becomes effective and in which the health care services organization is  
11 not required to provide health care services or benefits and cannot charge  
12 the participant or beneficiary a premium for any coverage during the period.

13           3. "Base premium rate" means, for each rating period, the lowest  
14 premium rate that could have been charged under a rating system by the  
15 accountable health plan to small employers for health benefits plans  
16 involving the same or similar coverage, family size and composition, and  
17 geographic area.

18           4. "Basic health benefit plan" means a plan that is developed by a  
19 committee established by the legislature and that is adopted by the director.

20           5. "Bona fide association" means, for a health benefits plan issued by  
21 an accountable health plan, an association that meets the requirements of  
22 section 20-2324.

23           6. "COBRA continuation provision" means:

24           (a) Section 4980B, except subsection (f)(1) as it relates to pediatric  
25 vaccines, of the internal revenue code of 1986.

26           (b) Title I, subtitle B, part 6, except section 609, of the employee  
27 retirement income security act of 1974 (P.L. 93-406; 88 Stat. 829; 29 United  
28 States Code sections 1001 through 1461).

29           (c) Title XXII of the public health service act.

30           (d) Any similar provision of the law of this state or any other state.

31           7. "Creditable coverage" means coverage solely for an individual,  
32 other than limited benefits coverage, under any of the following:

33           (a) An employee welfare benefit plan that provides medical care to  
34 employees or the employees' dependents directly or through insurance, ~~OR~~ **OR**  
35 reimbursement or otherwise pursuant to the employee retirement income  
36 security act of 1974.

37           (b) A church plan as defined in the employee retirement income  
38 security act of 1974.

39           (c) A health benefits plan issued by an accountable health plan as  
40 defined in this section.

41           (d) Part A or part B of title XVIII of the social security act.

42           (e) Title XIX of the social security act, other than coverage  
43 consisting solely of benefits under section 1928.

44           (f) Title 10, chapter 55 of the United States Code.



1 (g) A medical care program of the Indian health service or of a tribal  
2 organization.

3 (h) A health benefits risk pool operated by any state of the United  
4 States.

5 (i) A health plan offered pursuant to title 5, chapter 89 of the  
6 United States Code.

7 (j) A public health plan as defined by federal law.

8 (k) A health benefit plan pursuant to section 5(e) of the peace corps  
9 act (P.L. 87-293; 75 Stat. 612; 22 United States Code sections 2501 through  
10 2523).

11 (l) A policy or contract, including short-term limited duration  
12 insurance, issued on an individual basis by an insurer, a health care  
13 services organization, a hospital service corporation, a medical service  
14 corporation or a hospital, medical, dental and optometric service corporation  
15 or made available to persons defined as eligible under section 36-2901,  
16 paragraph 6, subdivisions (b), (c), (d) and (e).

17 (m) A policy or contract issued by a health care insurer or an  
18 accountable health plan to a member of a bona fide association.

19 8. "Demographic characteristics" means objective factors an insurer  
20 considers in determining premium rates. Demographic characteristics do not  
21 include health status-related factors, industry or duration of coverage since  
22 issue.

23 9. "Different policy forms" means variations between policy forms  
24 offered by a health care insurer, including policy forms that have different  
25 cost sharing arrangements or different riders.

26 10. "Genetic information" means information about genes, gene products  
27 and inherited characteristics that may derive from the individual or a family  
28 member, including information regarding carrier status and information  
29 derived from laboratory tests that identify mutations in specific genes or  
30 chromosomes, physical medical examinations, family histories and direct  
31 ~~analysis~~ ANALYSES of genes or chromosomes.

32 11. "Health benefits plan" means a hospital and medical service  
33 corporation policy or certificate, a health care services organization  
34 contract, A GROUP DISABILITY POLICY, A CERTIFICATE OF INSURANCE OF A GROUP  
35 DISABILITY POLICY THAT IS NOT ISSUED IN THIS STATE, a multiple employer  
36 welfare arrangement or any other arrangement under which health services or  
37 health benefits are provided to two or more individuals. Health benefits plan  
38 does not include the following:

39 (a) Accident only, dental only, vision only, disability income only or  
40 long-term care only insurance, fixed or hospital indemnity coverage, limited  
41 benefit coverage, specified disease coverage, credit coverage or Taft-Hartley  
42 trusts.

43 (b) Coverage that is issued as a supplement to liability insurance.

44 (c) Medicare supplemental insurance.

45 (d) Workers' compensation insurance.



1 (e) Automobile medical payment insurance.

2 12. "Health status-related factor" means any factor in relation to the  
3 health of the individual or a dependent of the individual enrolled or to be  
4 enrolled in an accountable health plan, including:

5 (a) Health status.

6 (b) Medical condition, including physical and mental illness.

7 (c) Claims experience.

8 (d) Receipt of health care.

9 (e) Medical history.

10 (f) Genetic information.

11 (g) Evidence of insurability, including conditions arising out of acts  
12 of domestic violence as defined in section 20-448.

13 (h) The existence of a physical or mental disability.

14 13. "Higher level of coverage" means a health benefits plan offered by  
15 an accountable health plan for which the actuarial value of the benefits  
16 under the coverage is at least fifteen per cent more than the actuarial value  
17 of the health benefits plan offered by the accountable health plan as a lower  
18 level of coverage in this state but not more than one hundred twenty per cent  
19 of a policy form weighted average.

20 14. "Index rate" means, as to a rating period, the arithmetic average  
21 of the applicable base premium rate and the highest premium rate that could  
22 have been charged under a rating system by the accountable health plan to  
23 small employers for a health benefits plan involving the same or similar  
24 coverage, family size and composition, and geographic area.

25 15. "Late enrollee" means an employee or dependent who requests  
26 enrollment in a health benefits plan after the initial enrollment period that  
27 is provided under the terms of the health benefits plan if the initial  
28 enrollment period is at least thirty-one days. An employee or dependent  
29 shall not be considered a late enrollee if:

30 (a) The person:

31 (i) At the time of the initial enrollment period was covered under a  
32 public or private health insurance policy or any other health benefits plan.

33 (ii) Lost coverage under a public or private health insurance policy  
34 or any other health benefits plan due to the employee's termination of  
35 employment or eligibility, the reduction in the number of hours of  
36 employment, the termination of the other plan's coverage, the death of the  
37 spouse, legal separation or divorce or the termination of employer  
38 contributions toward the coverage.

39 (iii) Requests enrollment within thirty-one days after the termination  
40 of creditable coverage that is provided under a public or private health  
41 insurance or other health benefits plan.

42 (iv) Requests enrollment within thirty-one days after the date of  
43 marriage.



1 (b) The person is employed by an employer that offers multiple health  
2 benefits plans and the person elects a different plan during an open  
3 enrollment period.

4 (c) A court orders that coverage be provided for a spouse or minor  
5 child under a covered employee's health benefits plan and the person requests  
6 enrollment within thirty-one days after the court order is issued.

7 (d) The person becomes a dependent of a covered person through  
8 marriage, birth, adoption or placement for adoption and requests enrollment  
9 no later than thirty-one days after becoming a dependent.

10 16. "Lower level of coverage" means a health benefits plan offered by  
11 an accountable health plan for which the actuarial value of the benefits  
12 under the health benefits plan is at least eighty-five per cent but not more  
13 than one hundred per cent of the policy form weighted average.

14 17. "Network plan" means a health benefits plan provided by an  
15 accountable health plan under which the financing and delivery of health  
16 benefits are provided, in whole or in part, through a defined set of  
17 providers under contract with the accountable health plan in accordance with  
18 the determination made by the director pursuant to section 20-1053 regarding  
19 the geographic or service area in which an accountable health plan may  
20 operate.

21 18. "Policy form weighted average" means the average actuarial value of  
22 the benefits provided by all health benefits plans issued by either the  
23 accountable health plan or, if the data are available, by all accountable  
24 health plans in the group market in this state during the previous calendar  
25 year, weighted by the enrollment for all coverage forms.

26 19. "Preexisting condition" means a condition, regardless of the cause  
27 of the condition, for which medical advice, diagnosis, care or treatment was  
28 recommended or received within not more than six months before the date of  
29 the enrollment of the individual under a health benefits plan issued by an  
30 accountable health plan. A genetic condition is not a preexisting condition  
31 in the absence of a diagnosis of the condition related to the genetic  
32 information and shall not result in a preexisting condition limitation or  
33 preexisting condition exclusion.

34 20. "Preexisting condition limitation" or "preexisting condition  
35 exclusion" means a limitation or exclusion of benefits for a preexisting  
36 condition under a health benefits plan offered by an accountable health plan.

37 21. "Small employer" means an employer who employs at least two but not  
38 more than fifty eligible employees on a typical business day during any one  
39 calendar year. As used in this paragraph, "employee" shall include the  
40 employees of the employer and the individual proprietor or self-employed  
41 person if the employer is an individual proprietor or self-employed person.

42 22. "Taft-Hartley trust" means a jointly-managed trust, as allowed by  
43 29 United States Code sections 141 through 187, that contains a plan of  
44 benefits for employees and that is negotiated in a collective bargaining



1 agreement governing the wages, hours and working conditions of the employees,  
2 as allowed by 29 United States Code section 157.

3 23. "Waiting period" means the period that must pass before a potential  
4 participant or beneficiary in a health benefits plan offered by an  
5 accountable health plan is eligible to be covered for benefits as determined  
6 by the individual's employer.

7 B. Coverage for a late enrollee begins on the date the person becomes  
8 a dependent if a request for enrollment is received within thirty-one days  
9 after the person becomes a dependent.

10 Sec. 3. Section 20-2304, Arizona Revised Statutes, is amended to read:  
11 20-2304. Availability of insurance; premium tax exemption

12 A. ~~Beginning on July 1, 1997,~~ As a condition of doing business in this  
13 state, each accountable health plan shall offer at least one health benefits  
14 plan on a guaranteed issuance basis to small employers as required by this  
15 section. All small employers qualify for this guaranteed offer of coverage.  
16 The accountable health plan shall provide a health benefits plan to each  
17 small employer without regard to health status-related factors if the small  
18 employer agrees to make the premium payments and to satisfy any other  
19 reasonable provisions of the plan that are not inconsistent with this  
20 chapter.

21 B. If an accountable health plan offers more than one health benefits  
22 plan to small employers, the accountable health plan shall offer a choice of  
23 all health benefits plans that the accountable health plan offers to small  
24 employers and shall accept any small employer that applies for any of those  
25 plans.

26 C. In addition to the requirements prescribed in section 20-2323, for  
27 any offering of any health benefits plan to a small employer, as part of the  
28 accountable health plan's solicitation and sales materials, an accountable  
29 health plan shall make a reasonable disclosure to the employer of the  
30 availability of the information described in this subsection and, on request  
31 of the employer, shall provide that information to the employer. The  
32 accountable health plan shall provide information concerning the following:

33 1. Provisions of coverage relating to the following, if applicable:

34 (a) The accountable health plan's right to change premium rates and  
35 the factors that may affect changes in premium rates.

36 (b) Renewability of coverage.

37 (c) Any preexisting condition exclusion.

38 (d) Any affiliation period applied by a health care services  
39 organization.

40 (e) The geographic areas served by health care services organizations.

41 2. The benefits and premiums available under all health benefits plans  
42 for which the employer is qualified.

43 D. The accountable health plan shall describe the information required  
44 by subsection C of this section in language that is understandable by the  
45 average small employer and with a level of detail that is sufficient to



1 reasonably inform a small employer of the employer's rights and obligations  
2 under the health benefits plan. This requirement is satisfied if the  
3 accountable health plan provides each of the following for each product the  
4 accountable health plan offers:

5 1. An outline of coverage that describes the benefits in summary form.

6 2. The rate or rating schedule that applies to the product,  
7 preexisting condition exclusion or affiliation period.

8 3. The minimum employer contribution and group participation rules  
9 that apply to any particular type of coverage.

10 4. In the case of a network plan, a map or listing of the areas  
11 served.

12 E. An accountable health plan is not required to disclose any  
13 information that is proprietary and protected trade secret information under  
14 applicable law.

15 F. An accountable health plan that issues a health benefits  
16 plan through a network plan may limit the employers that may apply for any  
17 health benefits plan offered by the accountable health plan to those eligible  
18 individuals who live, work, ~~or~~ or reside in the service area for the network  
19 plan of the accountable health plan.

20 G. On approval of the director, an accountable health plan may refuse  
21 to enroll a qualified small employer in a health benefits plan or in a  
22 geographic area served by the plan if the accountable health plan  
23 demonstrates that its financial or administrative capacity to serve  
24 previously enrolled groups and individuals would be impaired. An accountable  
25 health plan that refuses to enroll a qualified small employer may not enroll  
26 an employer of the same or larger size until the earlier of:

27 1. The date on which the director determines that the accountable  
28 health plan has the capacity to enroll a qualified small employer.

29 2. The date on which the accountable health plan enrolls a qualified  
30 small employer.

31 H. An accountable health plan that offers coverage to a qualified  
32 small employer shall offer coverage to all of the eligible employees of the  
33 qualified small employer and their eligible dependents.

34 I. An accountable health plan may request health screening and  
35 underwriting information on prospective enrollees to evaluate the risks  
36 associated with a qualified small employer who applies for coverage. The  
37 accountable health plan may use this information for the purposes of setting  
38 premiums, evaluating plan offerings and making reinsurance decisions. An  
39 accountable health plan shall not use this information to deny coverage to a  
40 qualified small employer or to an eligible employee or to an eligible  
41 dependent, except a late enrollee who attempts to enroll outside an open  
42 enrollment period.

43 J. ~~Notwithstanding the requirements of section 20-224, subsection B~~  
44 ~~and sections 20-837, 20-1010 and 20-1060, beginning July 1, 1996, accountable~~  
45 ~~health plans shall pay a premium tax of one per cent of the net premiums~~



1 ~~received for health benefits plans issued to small employers. Beginning July~~  
2 ~~1, 1997,~~ Accountable health plans are exempt from the premium taxes that are  
3 required by ~~this subsection,~~ section 20-224, subsection B and sections  
4 20-837, 20-1010 and 20-1060, ~~for the net premiums received for health~~  
5 ~~benefits plans issued to small employers,~~ INCLUDING THE NET PREMIUMS  
6 COLLECTED FROM COVERAGE ISSUED PURSUANT TO SECTION 20-2313, SUBSECTION C.  
7 Each accountable health plan shall notify the small employers to whom it  
8 provides coverage of the reductions in the premium tax as specified in this  
9 subsection.

10 K. The director may use independent contractor examiners pursuant to  
11 sections 20-148 and 20-159 to review the higher level of coverage and lower  
12 level of coverage health benefits plans offered by an accountable health plan  
13 insurer in compliance with this section. All examination and examination  
14 related expenses shall be borne by the insurer and shall be paid by the  
15 insurance examiners' revolving fund pursuant to section 20-159.

16 Sec. 4. Section 20-2309, Arizona Revised Statutes, is amended to read:  
17 20-2309. Renewability

18 A. At least sixty days before the date of expiration of a health  
19 benefits plan, an accountable health plan that provides a health benefits  
20 plan shall provide for written notice to the employer of the terms for  
21 renewal of the plan. The notice shall include an explanation of the extent  
22 to which any increase in premiums is due to actual or expected claims  
23 experience of the individuals covered under the employer's health benefits  
24 plan contract.

25 B. An accountable health plan may refuse to renew or may terminate a  
26 health benefits plan only if:

27 1. The employer fails to pay premiums or contributions in accordance  
28 with the terms of the health benefits plan of the accountable health plan or  
29 the accountable health plan does not receive premium payments in a timely  
30 manner.

31 2. The employer committed an act or practice that constitutes fraud or  
32 made an intentional misrepresentation of material fact under the terms of the  
33 health benefits plan.

34 3. The employer has failed to comply with a material plan provision  
35 relating to individual or employer participation rules as prescribed in  
36 subsection C of this section.

37 4. The accountable health plan has ceased to offer NEW coverage AND  
38 HAS TERMINATED OR CEASED TO RENEW ALL IN-FORCE COVERAGE in the group market  
39 pursuant to this section.

40 5. In the case of an accountable health plan that offers a health  
41 benefits plan through a network plan in this state, there is no longer any  
42 enrollee in connection with the accountable health plan who lives, resides or  
43 works in the service area of the accountable health plan or in the area  
44 served by the network plan for which the accountable health plan is



1 authorized to do business and the accountable health plan would deny  
2 enrollment pursuant to section 20-2304, subsection G.

3 6. In the case of an accountable health plan that offers a health  
4 benefits plan in the group market only through one or more bona fide  
5 associations, the membership of an employer in the association has ceased but  
6 only if that coverage is terminated uniformly without regard to any health  
7 status-related factor or any covered individual.

8 C. An accountable health plan may require that a minimum percentage of  
9 employees who are not covered under a spouse's or parent's employer's health  
10 benefits plan be enrolled in a plan if the percentage is applied uniformly to  
11 all plans that are offered to employers of comparable size.

12 D. An accountable health plan is not required to renew a health  
13 benefits plan with respect to an employer or individual if the accountable  
14 health plan:

15 1. Elects not to renew all of its health benefits plans that are  
16 issued to employers or individuals in this state.

17 2. Provides notice to the director at least five business days before  
18 the accountable health plan gives notice to each employer or individual  
19 covered under a health benefits plan of the intention to discontinue offering  
20 any health benefits plans in this state.

21 3. Provides notice of termination ~~OR NONRENEWAL~~ to each employer or  
22 individual covered under a plan at least one hundred eighty days before the  
23 ~~expiration~~ RENEWAL date of the plan. If the accountable health plan  
24 terminates coverage, the accountable health plan may not issue a health  
25 benefits plan to an employer in this state during the five year period  
26 beginning on the termination date of the last plan that was not renewed.

27 E. If an accountable health plan decides to discontinue offering a  
28 particular health benefits plan offered in the group market, the accountable  
29 health plan may discontinue that coverage only if the accountable health  
30 plan:

31 1. Provides notice to the director at least five business days before  
32 the accountable health plan gives notice to each employer or individual  
33 covered under that health benefits plan of the intention to discontinue  
34 offering that health benefits plan in this state.

35 2. Provides notice to each employer or individual covered under that  
36 health benefits plan at least ninety days before the date of the  
37 discontinuation of that coverage.

38 3. Offers to each employer whose coverage is discontinued pursuant to  
39 this subsection the option to purchase all other health benefits plans  
40 currently offered by the accountable health plan for employers in the group  
41 market uniformly without regard to any health status-related factor of any  
42 employee or a spouse or a dependent of the employee enrolled or individuals  
43 who may become eligible for that coverage.